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DATE NOTICE SENT TO ALL PARTIES: Nov/11/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left rotator cuff repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for Left rotator cuff repair is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a male with complaints of shoulder pain. A post arthrogram MRI of the left shoulder revealed a full thickness tear of the supraspinatus tendon with contrast extending from the glenohumeral joint space into the subacromial/subdeltoid recess through the full thickness tear. There was a partial tear and tendinosis of the infraspinatus tendon, and there' was moderate AC arthrosis and mild glenohumeral arthrosis. On, the patient was seen in xxxx. Objectively, he had limited range of motion with forward flexion to 90 degrees, and had 4/5 strength with forward flexion and external rotation. Had a positive Hawkins test, positive Neer impingement sign and positive empty can test. Assessment was left shoulder full thickness rotator cuff tear with acromioclavicular joint arthritis, and arthroscopy with rotator cuff pair as well as possible biceps tenodesis was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On, a utilization review report noted the request included a biceps tenodesis, and there was no imaging evidence to support the need for that procedure. It was noted the biceps tendon was not described in the MRI report or in the second opinion note and the glenoid labrum was described as without a tear. Modification could not be performed and therefore the entire request was non-certified.

On, a utilization review report noted the request was non-certified as there was no significant findings involving the biceps that would indicate the need for surgical intervention. Therefore the prior denial was supported and the request was non-certified.

The official MRI report submitted for this review, noes there is no definite labral tear, and there was no indication of biceps pathology.

The need for a biceps tenodesis has not been established.

It is the opinion of this reviewer that the request for Left rotator cuff repair is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)